

# National Rural Health Mission

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Under the mandate of the National Common Minimum programme (NCMP) of the UPA Government, health care is one of the 7 thrust areas wherein it is proposed to increase the expenditure in health sector from 0.9 % of GDP to 2-3% of GDP over the next five years. Accordingly, a National Rural Health Mission (NRHM) was launched on 12<sup>th</sup> April 2005 for a period of 7 years (2005-2012), *i.e.* for two years of Tenth Plan and full Eleventh Plan. The objective is to provide accessible, affordable, accountable, effective and reliable health care, especially to poor and vulnerable sections of the population in rural areas. The Mission provides an overarching umbrella, subsuming the existing programs of the Ministry. It is operational over the entire country with special focus on 18 States *viz.* 8 empowered action group states (Bihar, Jharkhand, M.P, Chhattisgarh, U.P., Uttaranchal, Orissa and Rajasthan), 8 northeast states (Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura), Himachal Pradesh, and Jammu and Kashmir.

The Mission is an articulation of the commitment of the Government to increase the outlays for health from 0.9% to 2-3% of GDP over the next five years and to undertake systemic correction of the health system to effectively utilize such increased outlays for sustainable outcomes. The plan of action of the Mission aims at reducing regional imbalances in health outcomes by relating health to determinants of good health *viz.* sanitation, nutrition and safe drinking water; pooling resources; integration of organizational structures; optimization of health manpower, including Ayurveda, Unani, Siddha and Homeopathy (AYUSH); decentralization and district management of health program akin to Sarva Shiksha Abhiyan; community participation and ownership of assets; induction of management and finance personnel into the district health system, and operationalizing effective referral hospital care at CHC level as per the Indian Public Health Standards in each block of the country. More specifically, the key strategies under the Mission are as follows:

## ASHA

The Accredited Social Health Activist (ASHA) is envisaged to be a trained female voluntary Community Health Worker in the eight EAG states, Assam, and Jammu and Kashmir. Other states also have the flexibility to adopt it under RCH-II. ASHAs would reinforce community action for universal immunization, safe/

institutional delivery, other reproductive and health-related services, newborn care, prevention of water-borne and other communicable diseases, nutrition and sanitation. ASHAs would be chosen by the Panchayat and be fully accountable to them. Though she would not be paid any salary she would be entitled for performance linked incentives under different program. Fully anchored in the anganwadi system, ASHAs would work in close coordination with the ANM and AWW. ASHAs would be provided with a basic drug kit including AYUSH drugs. She would also be a depot holder for contraceptives and IEC materials developed for villages.

## Strengthening of Infrastructure

Additional SC/PHC/ CHCs are to be set up to bring the number in line with the current population norm. Repair/ renovation of the existing public health facilities is planned, and norms are being developed for support to the states for construction of new buildings and maintenance to the existing buildings. Incentives are being devised to encourage the State Governments for filling up vacant posts of ANMs/LHVs/MPWs. An annual support of Rs. 10,000 as untied fund to be spent in direct supervision of the Panchayats has been given to each sub center. Fifty percent of the PHCs are proposed to be made operational on 24 X 7 basis by including an AYUSH practitioner. All the CHCs are to be upgraded over the mission period to the Indian Public Health Standards (IPHS), with posting of additional specialists.

IPHS is a novel concept to fix benchmarks of infrastructure including building, manpower, equipments, drugs, quality assurance through introduction of treatment protocols. All CHCs are also to be made operational as First Referral Units (FRUs), providing emergency obstetric and new born care. Accountability to public is to be enforced through a prominently-displayed Citizens Charter (indicating the range of services and the rights of citizens) to be monitored through Hospital Management Society. The Rogi Kalyan Samitis are envisaged at all levels, for which support of Rs one lakh per CHC/PHC is being given. At all levels, additional drugs are also being provided to improve their credibility.

## Decentralized Planning

Flexible, Decentralized Planning is the pivot on which the entire concept of the Mission revolves. The planning process under the guidance of the Village Health and

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Sanitation Committee is to start right from the village level. However, till such time that adequate capacity is built, the districts would be the starting points for this exercise. The district plans would thereafter converge into state plans. Planning would be taken up for the entire mission period as well as for each financial year. The district plans would be appraised by the states, who thereafter would send the state plans to the Center. These plans would be approved at the Central level before the beginning of the financial year.

### Institutional Arrangements under NRHM

The Mission Steering Group (MSG) has been set up at the Center chaired by the Union Minister of Health and Family Welfare, with Deputy Chairman of the Planning Commission, Ministers of the Panchayati Raj, Rural Development, Human Resource Development, Secretary Expenditure and other senior officials from the Central as well as the State Governments and ten health professionals as members. The Empowered Programme Committee has also been set up and is chaired by the Secretary (H and FW). The Integration of the Departments of Health and Family Welfare at the national level has been replicated at the state levels. Advisory Group on Community health action has been set up to guide the process of community participation. Most states have also set up the State Health Mission to be chaired by the Chief Minister. The various societies at the state and the district level have been merged into an Integrated Society at the state level where it is the executive arm of the State Health Mission. The District Health Missions are being formed under the chairmanship of Zilla Parishad. The Integrated District Society is the executive arm of the District Health Mission. At various levels the Hospital Management Society are being constituted to foster community participation in the management of hospitals. The Village Health and Sanitation Committee is the farthest link and guides the process at the village level.

### Capacity-Building under NRHM

The services of professional, including MBAs, chartered accountants etc, have been contracted in the EAG states to set up the PMU. These professionals are assigned specific roles under the organogram of the State and District Health Society so as to bring them into the mainstream. Formation of the Mission teams both in terms of number as well as skills is one of the important preparatory activities. For ASHAs a minimum 23 day training period followed by on-the-job training is envisaged. Training Modules for this purpose have been developed and the training of trainers is currently on. ANMs and AWWs are also to be associated in the ASHA training process. A mentoring group comprising of eminent health professionals has been set up to guide the process. MNGOs are to be involved at the district level in planning process. Adequate provision to be made out of the Mission funds for training of the members of the Village

Health and Sanitation Committee, Zilla Parishad, Hospital Management Committee to equip them with the skills to take up planning, implementation, and monitoring of the Mission activities.

### Public-Private Partnership under NRHM

The Mission would forge suitable public-private partnerships to meet the deficiencies in the public health delivery system. Guidelines are being developed for accreditation of private health providers. Pilots would be run on social franchising, contracting etc in selected districts, and based on the outcome they would be implemented on wider geographical area.

### Monitoring and Evaluation under NRHM

A baseline survey is to be taken up at the district level incorporating Facility Survey (including private facilities) as well as survey of the Households. The baseline survey is to help the Mission in fixing decentralized monitorable goals and indicators. There would be community monitoring at the village level. The Panchayati Raj institutions, Rogi Kalyan Samitis, Quality Assurance Committees at the State and District level, State and District Health Missions, Mission Steering Group at the Central level, Planning Commission are to be the eventual monitor of the outcomes. External evaluation is also to be taken up at frequent intervals.

### Preparatory Activities Undertaken Under NRHM

The year 2005-06 was the preparatory phase of the Mission, and the following preparatory activities have been undertaken :

1. The departments of health and Family Welfare have been merged at the GoI as well as the state level.
2. Designing the strategies for the various initiatives of the Mission. This was done after involving all the stakeholders including the state governments, NGOs, public health experts etc. Several Task Groups were constituted for devising the strategies for the various activities, and five of the task groups have already submitted their recommendations.
3. The Institutional framework of the Mission including the Mission Steering Group and the Empowered Programme Committee have been set up and meetings have been held.
4. The generic guidelines for implementation of the different activities under NRHM have been disseminated to the stake holders.
5. The Mission has been formally launched in the states of M.P., Chattisgarh, Rajasthan, Orissa, Bihar, U.P., Uttaranchal and the N.E. States.
6. An Advisory Group on Community Action under NRHM has been constituted. This group has already met twice and is deliberating on the role of the Community based organisations under the NRHM.
7. The selection and training of ASHA has started. The training module of ASHA has been finalized and a

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training for the trainers has been convened at Central / State / District levels.

8. The states have set up state and district health Mission and appointed Mission Directors.
9. The states are finalizing the modalities for merger of the various societies under a single state health society.
10. The plan of action for intersectoral convergence is being drawn up under the committee on intersectoral convergence. Letters have been written to the states under the common signatures of the Secy (HFW), Secy. (DWCD), and Secy (AYUSH) so that the initiatives of the various departments can be aligned towards the strategies of the Mission.

The efforts to reduce the unacceptably high Infant mortality rate in India must address the issues of safe motherhood, monitoring of birth weight, breast-feeding, home care, referral/transport facilities at Primary health care facilities and clean delivery kit etc. It has also to be noted that regardless of primary cause of death, a large number of neonatal deaths occur among LBW babies.

Thus the important role of maternal nutrition and regular health check ups during pregnancy has also to be brought to the fore front of the roles envisaged for ASHA and AWW. With assured availability of adequate equipments, BCC and community support the trilogy of the ANM, AWW and ASHA can substantially reduce the burden of events which lead to the high IMR.

The National Rural Health Mission is a statement of hope and conviction. The Government is committed to achieving the goals laid down in National Population Policy and National Health Policy. For the underserved poor in the village level, the Mission spells hope in the form of a voluntary trained community health activist (ASHA) equipped with a drug kit; improved hospital facility at CHC level measurable as per the Indian Public Health Standards (IPHS); availability of drugs for generic common ailments at health centres; access to universal immunization; referral and escort services for institutional delivery; nutrition and medical care at Anganwadi level on a monthly basis on the health day, and through mobile medical unit at district level and availability of household toilets.